US Family Health Plan

Prior Authorization Request Form for

Deucravacitinib **(Sotyktu)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1

Please complete patient and physician information (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID #: ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2

Please complete clinical assessment:

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient 18 years of age or older?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. What is the diagnosis or indication?	☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – Proceed to question **8** ☐ Other indication or diagnosis – **STOP: coverage not approved.**	
8. Has the patient had an inadequate response to non-biologic systemic therapy (for example: methotrexate or corticosteroids)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

Question	Yes	No
9. Will the patient be using the requested medication concomitantly with other Targeted Immunomodulatory Biologics (TIB) agents (for example, Enbrel, Remicade)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Is the provider aware of the FDA safety alerts and warnings and precautions?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient had evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes **Sign and date below.**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

______________________________ Prescriber Signature

__________ Date